

COMMUNITY-BASED PARENTING AND FAMILY SUPPORT INTERVENTIONS AND THE PREVENTION OF DRUG ABUSE

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Abstract

This paper presents a model for the development of a comprehensive, multilevel, preventively-oriented parenting and family support strategy to reduce family risk factors associated with drug abuse in young people. If parenting interventions are to make a significant impact at a population level on the prevalence of dysfunctional parenting practices, there is a need for an ecological approach to parenting support. Such an approach needs to target a variety of social contexts that are in a position to provide parents with access to evidence-based parenting interventions. The Triple P-Positive Parenting Program is discussed as an example of such an approach to illustrate the distinguishing features of a population level strategy. The core constructs underpinning the Triple P system include the promotion of parental self-regulation (self-sufficiency, self-efficacy, self-management, personal agency, and problem solving), through making parenting programs of adequate intensity widely available in the community through flexible delivery modalities (individual, group, telephone assisted and self-directed). The system comprises a tiered continuum of increasingly intensive parenting interventions ranging from media interventions with wide reach, to intensive behavioural family interventions with narrow reach for high-risk families where parenting problems are complicated by other factors including marital conflict, parental mood disturbance, and lack of social support. The scientific basis of the system of intervention and possible directions for future research is discussed. © 2000 Elsevier Science Ltd.

A child's family provides the first and most important social context for human development and as such it is not surprising that disturbances in family relationships and dysfunctional parenting practices have been shown to be powerful early predictors of drug abuse in adolescence. Adolescents at risk of becoming involved in drug abuse are more likely to come from homes where family management practices have been disrupted (Catalano & Hawkins, 1996; Dishion, Patterson, Stoolmiller, & Skinner, 1991; Hawkins, Catalano, & Miller, 1992). Where family environments are characterized by parental conflict and instability, harsh unpredictable discipline practices, inadequate supervision and monitoring, parental rejection and insecure attachments and parental substance use, children are at greater risk of both conduct problems and becoming involved in drug use (e.g., Brody & Forehand, 1993; Brook, Brook, Gordon, Whiteman, & Cohen, 1990; Farrell & White, 1998; Hops, Tildesley, Lichtenstein, Ary, & Sherman, 1990; Kilpatrick et al., 2000).

Poor and inconsistent family management practices place children at risk for both drug abuse and delinquency (Hawkins et al., 1992). Children with early onset conduct problems, the so-called "early starters," show pronounced cross-situational behavior problems which predict not only later delinquency but also concurrent and later substance use (Brook et al., 1990; Hawkins et al., 1992; Kandel, 1982; Kellam, Brown, & Fleming, 1983; Loeber, 1988, 1990). Early persistent behavior difficulties such as aggression, shyness (particularly when co-existing with aggression), conduct problems, and impulsive behaviors, place children at risk for drug use. There are significant cross-sectional and longitudinal correlations between serious conduct problems and self-reported use of multiple substances (Hawkins et al., 1992; Kellam, Ensminger, & Simon, 1980; Van Kammen, Loeber, & Stouthamer-Loeber, 1991). Conduct-problem behavior is more likely to begin before drug use than vice versa; and an escalation of delinquent or antisocial acts is often accompanied by substance use (Elliott, Huizinga, & Ageton, 1985; Prinz, 1998). At a broader level, child behavior problems during toddlerhood, in early elementary school, or in middle to late

childhood generally increase risk for subsequent substance use, academic difficulties, and adolescent adjustment problems. Conversely, family support has been shown to be a significant predictor of positive adjustment in childhood and adolescence, and indirect evidence suggests that family support is a protective factor for adolescent substance use and conduct problems (Cauce, Reid, Landesman, & Gonzales, 1990; Cohen & Wills, 1985; Rutter, 1979; Wills, Vaccaro, & McNamara, 1992).

The need for parenting interventions as part of drug abuse prevention

There is little doubt that many parents find the parenting experience stressful, and concerns about children's involvement in drug use is an extremely anxiety provoking issue for many parents. Raising children is increasingly occurring in a broader social context of uncertainty and social change. Current high levels of divorce mean that many children are often exposed to unstable, conflict ridden family environments and are raised in single-parent households (Amato & Keith, 1991; Pett, Wampold, Turner, & Vaughan-Cole, 1999). Only a minority of parents undertake any formal parent education, and participation rates tend to be low amongst groups of parents whose children are considered at highest risk (Sanders et al., 1999). The increasing mobility of the population means that many parents raise their children in relative social isolation from extended family support networks who in the past provided counsel and advice on child rearing matters.

Recognition of the important role of family factors in drug abuse has led to the development of a number of prevention-oriented parenting and family interventions to reduce family risk factors and increase family protective factors associated with drug abuse (see Dishion & Kavanagh, in press; Kumpfer & Turner, 1990; Spoth & Redmond, 1995; Spoth, Redmond, & Shin, 1998). While there is some evidence that parenting interventions have an important role to play in drug abuse prevention, a broader ecological perspective is needed to develop parenting competencies. The current paper outlines a model for the development of a comprehensive, preventively focussed intervention targeting key social contexts within the community that influence parenting practices. These social contexts include the mass media, the primary health care system, the school system, work sites, and broader political system. This article first examines the strengths and limitations of programs designed to promote more effective parenting and then highlights the criteria that must be met to move to a population- based approach. The Triple P-Positive Parenting Program is used as an example to illustrate key principles of intervention development targeting different social contexts and outlines some possible direction for future research.

The strengths and limitations of parenting intervention

Several studies have demonstrated that parenting and family interventions are important to reducing family risk factors associated with subsequent substance use (Catalano, Gaine, Fleming, Haggerty, & Johnson, 1999; Dishion & Andrews, 1995; Hawkins et al., 1992; Irvine, Biglan, Smolkowski, Metzler, & Ary, 1999; Spoth, Redmond, & Lepper, 1999; Spoth et al., 1998; Tremblay, Pagani-Kurtz, Masse, Vitaro, & Pihl, 1995). Of the different family intervention approaches the strongest empirical support is for behavioral family interventions (BFI's) based on social learning models (Lochman, 1990; McMahon, 1999; Sanders, 1996, 1998; Taylor & Biglan, 1998). These programs emphasize the importance of specific parenting skills such as positive attention and communication, parental monitoring and supervision, limit setting and problem solving and negotiation. There is also some evidence that parenting interventions can be effective when applied at a universal population level (e.g., Spoth et al., 1998). There is clear evidence that BFI can benefit children with disruptive behavior disorders, particularly children with oppositional defiant disorders (ODD) and their parents (Forehand & Long, 1988; Webster-Stratton, 1994). Treatment outcome studies often report large effect sizes (Serketich & Dumas, 1996), with good maintenance of treatment gains (Forehand & Long, 1988). Treatment effects have been shown to generalize to school settings (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderbunk, 1991) and to various community settings (Sanders & Glynn, 1981). Parents participating in these programs are generally satisfied consumers (Webster-Stratton, 1989).

There is also increasing evidence that parenting interventions can have a pervasive impact on the quality of life of families. Not only have child conduct problems been shown to reduce significantly with BFI, but there is increasing evidence of positive collateral effects in other areas of family functioning as well, including reduced marital conflict over parenting (Dadds, Schwartz, & Sanders, 1987), parental distress such as depression and stress (Connell, Sanders, & Markie-Dadds, 1997; Sanders & McFarland, in press), parental anger and hostility (Sanders & Gravestock, 2000), and increased parental sense of competence (Connell et al., 1997). Many of the main findings of parent training studies have been replicated across many different investigators. Several different delivery modalities appear to produce similar positive outcomes (e.g., individual, group, telephone assisted and self-directed), which

mean considerable flexibility in how parenting interventions can be delivered are possible. The interventions have been shown to be effective with a range of family types and ethnic groups.

Despite these impressive achievements, there is little room for complacency. The majority of children with significant conduct problems receive no professional assistance at all (Zubrick et al., 1995), and those who do typically do not receive empirically supported parenting interventions (Taylor & Biglan, 1998). Although positive outcomes have been reported in many trials, a recent review by Morrissey-Kane and Prinz (1999) showed that many practitioners experience difficulties engaging families. There are unacceptably high levels of “no-shows” for initial appointments and noncompletion of high-risk families.

Rationale for Population Perspective

Partly as a consequence of continuing problems of low reach of empirically supported family interventions, a different approach is required to increase access and 932 M. R. SANDERS participation. To improve the reach and participation of families a comprehensive, multilevel, population-based strategy is required. A multilevel prevention approach to promote positive parenting of preadolescent children is used to illustrate key principles of prevention programming using a community or population level framework. This strategy needs to be designed to enhance parental competence, prevent dysfunctional parenting practices, and promote better teamwork between parenting partners, thereby reducing an important set of family risk factors associated with drug use and behavioral and emotional problems in children. A population perspective to improving parenting and family functioning views family relationships as embedded within and potentially affected by several different social contexts in the community. These social contexts can be targeted to create “family friendly” environments that provide increased levels of access to parenting support.

To successfully mount a population level prevention approach targeting relevant social contexts for families requires several scientific and clinical criteria to be met first (Taylor, 1999). These include the following:

Knowledge of the prevalence and incidence of child outcomes being targeted: A number of studies in the US, Canada, United Kingdom, New Zealand, Germany, and Australia have established the prevalence rates of behavioral and emotional problems in children, showing that about 18% of children experience behavioral or emotional problems (e.g., Zubrick et al., 1995). Parents themselves report a high level of concern about their child’s behavior and adjustment. For example, in a recent epidemiological survey of parents in Queensland, Australia, 28% said “yes” when asked “Do you consider your child to have a behavioral or emotional problem?” (Sanders et al., 1999), thus reflecting the high degree of parental concern about children.

Knowledge of the prevalence and incidence of family risk factors: Several studies which have established the incidence and prevalence of child behavior problems have also examined parenting practices and disciplinary styles and marital conflict. For example, Sanders et al. (1999) found that 70% of parents under the age of 12 years reported they smack their children at least occasionally, 3% reported hitting their child with an object other than their hand, and 25% of parents reported significant disagreements with partners over parenting issues. Others have examined prevalence rates for specific types of parental disciplinary practices (e.g., Straus & Stewart, 1999).

Knowledge that changing specific family risk and protective factors leads to a reduction in the incidence and prevalence of the target problem is necessary (e.g., conduct problems and drug use: An effective population level parenting strategy must make explicit the kinds of parenting practices that are considered harmful to children. The core constructs believed to underpin competent parenting need to be articulated so that targets for intervention can be specified. The validity of the model of family intervention would be greatly strengthened if improvements in child functioning were shown to be directly related to specific changes which decrease dysfunctional and increase competent parenting variables specified by the model. For example, there is now considerable evidence to support the proposition that teaching parents positive parenting and consistent disciplinary and monitoring skills results in significant improvements in the majority of oppositional and disruptive children, particularly young children, attesting to the importance of reducing patterns of coercive parent-child interaction (Patterson, 1982).

Having effective family interventions: A population perspective requires a range of effective family interventions to be available. There is sufficient evidence showing that BFI’s are an effective approach in modifying important aspects of family functioning. Community-based parenting and family support interventions 933 Any approach advocated must also be subjected to comprehensive and systematic evaluation with rigorous scientific controls using either intrasubject replication designs or traditional randomized controlled clinical trials with sufficient statistical

power to detect meaningful differences between intervention and control conditions. An effective family intervention strategy should seek to demonstrate that short-term intervention gains maintain over time, are cost effective relative to no intervention, alternative interventions or usual community care, and are associated with high levels of consumer satisfaction and community acceptance. It is not sufficient just to demonstrate that a strategy results in improvements in family interaction based exclusively on parental reports, although this is a necessary first step. The mechanisms purported to underlie the improvements in family interaction must also be demonstrated to change and be responsible for the observed improvements.

Family interventions must be culturally appropriate: An effective population strategy should be tailored in such a way that it is accessible, relevant and respectful of the cultural values, beliefs, aspirations, traditions and identified needs of different ethnic groups. Factors such as family structure, roles and responsibilities, predominant cultural beliefs and values, child raising practices and developmental issues, sexuality and gender roles may be culturally specific and need to be addressed. While there is much to learn about how to achieve this objective in a multicultural context, it is likely that sensitively tailored parenting programs can be effective with a variety of ethnic and cultural groups. However, it is important to note that both within and between cultural groups, there can be considerable heterogeneity, some of which may be contributed to by socioeconomic differences. Hence, the examination of cultural differences in child rearing practices needs to control for socioeconomic variables such as poverty, both within and between cultures. Parenting interventions are more likely to be used when program developers are attentive to cultural variables that may influence the acceptability and therefore the desirability of an intervention to different minority groups. It is important that the multicultural context within which assessment, intervention and research programs operate is made clear in evaluations. There is an ethical imperative to ensure that interventions designed to develop skills in parents and children in the dominant culture are not at the expense of language and other competencies or values in the child's own culture.

Interventions need to be widely available: A key assumption of a population approach is that parenting and other family intervention strategies should be widely accessible in the community. It is important that barriers to accessing parenting and other family intervention programs are reduced. Inflexible clinic hours may prevent working parents from participating in parenting programs. Families most in need of help with emotional and behavioral problems often do not have or seek access to support services. Families who are socially and economically disadvantaged are less likely to refer themselves for help. In addition, the family intervention services may be viewed as coercive and intrusive, rather than helpful. Use of the internet, media, and self-help interventions all have the potential to increase the reach of interventions to hard to access groups; however, such approaches require further systematic evaluation.

The Triple P- Positive Parenting Program: An Example of a Multilevel Preventive Intervention

The Triple P-Positive Parenting Program is a form of behavioral family intervention based on social learning principles (e.g., Patterson, 1982). This approach to the treatment and prevention of childhood disorders has the strongest empirical support of any intervention with children, particularly those with conduct problems (see Kazdin, 1987; Sanders, 1996; Taylor & Biglan, 1998; Webster-Stratton & Hammond, 1997). Triple P has the broad aim of enhancing family protective factors and reducing risk factors associated with severe behavioral and emotional problems in preadolescent children, and therefore targets several important child and family risk factors linked to drug use. Specifically the program aims to: (1) enhance the knowledge, skills, confidence, self sufficiency and resourcefulness of parents of preadolescent children; (2) promote nurturing, safe, engaging, nonviolent, and low conflict environments for children; and (3) promote children's social, emotional, language, intellectual, and behavioral competencies through positive parenting practices.

The program targets children from birth to age 12, although a version of the program for parents of adolescents is being trialed at present. The program adopts a public health perspective to family intervention which explicitly recognizes the role of the broader ecological context for human development (e.g., Biglan, 1995; Mrazek & Haggerty, 1994; National Institute of Mental Health, 1998). As pointed out by Biglan (1995), the reduction of antisocial behavior in children requires the community context for parenting to change. Triple P's media and promotional strategy as part of a larger system of intervention aims to change this broader ecological context of parenting. It does this by normalizing parenting experiences (particularly the process of participating in parent

education), by breaking down parents' sense of social isolation, increasing social and emotional support from others in the community, and to validate and publicly acknowledge the importance and difficulties of parenting. It also involves actively seeking community involvement and support in the program by the engagement of key community stakeholders (e.g., community leaders, businesses, schools and voluntary organizations).

Targeting different social contexts for parenting and family support

Media strategy

There is little doubt that the media has a pervasive influence on our lives. What parents see, hear and read about in the mass media can influence community attitudes towards children and parenting. Much of the media coverage of issues concerning the problems of youth serve to undermine parental confidence. Both news and current affairs treatments on television frequently sensationalize issues involved, raise alarm and anxiety of parents, and rarely depict solutions to these problems. Several authors have noted that the media has been underutilized by family intervention researchers (e.g., Biglan, 1992). Evidence from the public health field shows that media strategies can be effective in increasing community awareness of health issues and has been instrumental in modifying potentially harmful behavior such as cigarette smoking, lack of exercise and poor diet (Biglan, 1995; Sorensen, Emmons, Hunt, & Johnson, 1998). A universal parenting intervention using the media can use health promotion and social marketing strategies to: (1) promote the use of positive parenting practices in the community; (2) increase the receptivity of parents towards participating in the program; (3) increase favorable community attitudes towards the program and parenting in general; (4) destigmatize and normalize the process of seeking help for children with behavior problems; (5) increase the visibility and reach of the program; and (6) counter alarmist, sensationalized or parent blaming messages in the media.

Within the Triple P system a promotional campaign is coordinated locally by a Triple P coordinator. Program coordinators use a media resource kit, which currently consists of the following elements: (1) a 30-second television commercial promoting the program for broadcast as a community service announcement (CSA); (2) a 30-second radio commercial announcing the program; (3) a series of 40, 60-second audio sound capsules on positive parenting; (4) 52 newspaper columns on Triple P dealing with common parenting issues and topics of general interest to parents; (5) self-directed information resources in the form of positive parenting tip sheets and a series of videos for parents, which depict how to apply behavior management advice to common behavior and developmental problems; (6) printed advertising materials (posters, brochures, business cards, coffee mugs, positive parenting tee shirts, fridge magnets); (7) a series of press releases, and sample letters to editors of local television, radio, newspapers and community leaders requesting their support and involvement with the program; and (8) a program coordinator guide to use of the media kit.

To illustrate such an approach, a media campaign on parenting based around a television series ("Families") which was shown on a commercial television network in New Zealand is discussed below. The centerpiece of this media campaign was 13, 30-minute episodes of an infotainment style television series, "Families." This program was shown at prime time (7:30 pm) on a Wednesday evening on the TV 3 commercial television network in October–December, 1995. The program was funded by New Zealand on Air and private business donations. It used an "infotainment" style television program to ensure the widest reach possible for Triple P. Such programs are very popular in both Australia and New Zealand and according to ratings data, frequently attract around 20–35% of the viewing audience (Neilson, 1998). The series used an entertaining format to provide practical information and advice to parents on how to tackle a wide variety of common behavioral and developmental problems in children (e.g., sleep problems, tantrums, whining, aggression) and other parenting issues. A 5- to 7-minute Triple P segment each week enabled parents to complete a 13-session Triple P program in their own home through the medium of television. A cross-promotional strategy using radio and the print media was also used to prompt parents to watch the show and inform them of how to contact a Triple P infoline for more information about parenting. "Families" fact sheets, which were specifically designed parenting tip sheets, were also available through writing to a Triple P Centre or calling a Triple P information line, or through a retail chain.

A carefully planned media campaign has the potential to reach a broad cross section of the population and to mobilize community support for the initiative. Hence, it is important to engage key stakeholders before the outreach commences to mobilize community support in advance. The primary target groups for a campaign are the parents and carers of children who may benefit from advice on parenting. However, media messages are also seen or heard by professionals, politicians and their advisers and at various levels of government, voluntary organizations, as well as nonparent members of the public. These groups may be able to support other levels of the program through referring parents to the program, facilitating funding or direct donations.

There have been two randomized controlled trials evaluating the programs impact on parenting practices when the series was shown to parents at home on videotapes. Sanders, Montgomery, and Brechman-Toussaint (in press) randomly assigned parents of preschool aged children to either watching “Families” or to a no-intervention control group. Parents watching the series reported a significant increase in parenting sense of competence, reduced stress and fewer behavior difficulties, compared to controls. These short-term effects were maintained at 6-months follow-up for the intervention group. A second study (Sanders & Shallcrass, 2000) replicated the main findings, but in addition showed that fathers as well as mothers reported similar effects and less conflict of parenting. Although these findings represent the effects of the series under ideal conditions of viewing (watching all episodes), they confirm other data showing the potential of videotapes as a medium for teaching parenting skills (e.g., Webster-Stratton, 1994). Future research on the effects of media intervention will be strengthened by the inclusion of independent observational data on parent-child interaction.

The primary health care system

Another important social context for parenting interventions involves consultations with primary health care providers such as family doctors, maternal and child health nurses, and home visitors. A parenting intervention delivered through primary health care services has wide reach because a significant proportion of parents take their children to them and are therefore more readily accessible to parents than traditional mental health services. For example, family doctors and pediatricians are the most likely professional parents speak to about child behavior problems (Sanders et al., 1999). These services are well positioned to provide brief prevention-oriented parenting programs because parents see primary care practitioners as credible sources of information about children and are not associated with the stigma often attached to seeking specialist mental health services. For example, general medical practitioners are frequently asked by parents for advice regarding their children’s behavior (Christopherson, 1982; Triggs & Perrin, 1989). Family doctors are the most likely source of professional assistance sought by parents of children with behavioral and emotional problems and are seen by parents as credible sources of advice for a wide range of health risk behaviors (Sanders & Markie-Dadds, 1997).

However, primary care providers are typically not well trained in providing behavior management advice, hence adequate training is essential. The Triple P professional training program for general practitioners, child health nurses and other primary care providers is designed to improve early detection and management of child behavior problems, and to develop closer links with community-based mental health professionals and other specialist family services, including appropriate referral mechanisms.

Two levels of brief intervention have been developed to meet the needs of primary care practitioners. The first, known as *Selective Triple P* is a brief, one-session, usually 20-minute consultation, for parents with specific concerns about their child’s behavior or development. A series of parenting tip sheets are used to provide basic information to parents on the prevention and management of common problems in each of 4 age groups (infants—Markie-Dadds, Turner, & Sanders, 1998; toddlers—Turner, Markie-Dadds, & Sanders, 1996; preschoolers—Turner et al., 1996; primary school-aged children—Sanders, Turner, & Markie-Dadds, 1996). Four videotape programs complement the tip sheets for use in brief primary care consultations. All materials are written in plain English and are understandable at a grade 6 reading level, are gender sensitive, and avoid technical language and colloquial expressions, which might constitute barriers for parents from non-English-speaking backgrounds. Each tip sheet suggests effective practical ways of preventing or solving common child management and developmental problems. Information is provided within a brief consultation format (up to 30 minutes), which clarifies the presenting problem, explains the materials and tailors them to the family’s needs. Families are invited to return for further help if they have any difficulties.

This level of intervention is designed for the management of discrete child problem behaviors that are not complicated by other major behavior management difficulties or family dysfunction. The emphasis is on the management of specific child behavior rather than developing a broad range of child management skills. Key indicators for a Level 2 intervention include: (1) the parent is seeking information, hence the motivational context is good; (2) the problem behavior is relatively discrete; (3) the problem behavior is of mild to moderate severity; (4) the problem behavior has a recent onset; (5) the parents and/or child are not suffering from major psychopathology; (6) the family situation is reasonably stable; and (7) the family has successfully completed other levels of intervention and has returned for a booster session.

The second, known as *Primary Care Triple P*, is another selective more intensive prevention strategy targeting parents who have mild and relatively discrete concerns about their child’s behavior or development (e.g., toilet training, tantrums, sleep disturbance). It is a four-session, 20-minute information based strategy that incorporates active skills training and the selective use of parenting tip sheets covering common developmental and behavioral

problems of preadolescent children. It also builds in generalization enhancement strategies for teaching parents how to apply knowledge and skills gained to nontargeted behaviors and other siblings.

The first session clarifies the history and nature of the presenting problem (through interview and direct observation), negotiates goals for the intervention and sets up a baseline monitoring system for tracking the occurrence of problem behaviors. Session 2 reviews the initial problem to determine whether it is still current; discusses the results of the baseline monitoring, including the parent's perceptions of the child's behavior; shares conclusions with the parent about the nature of the problem (i.e., the diagnostic formulation) and its possible aetiology; and negotiates a parenting plan (using a tip sheet or designing a planned activities routine). This plan may involve the introduction of specific positive parenting strategies through discussion, modeling or presentation of segments from *Every Parent's Survival Guide* video (Sanders, Markie-Dadds, & Turner, 1996). This session also involves identifying and countering any obstacles to implementation of the new routine by developing a personal coping plan with each parent. The parent/s then implement the program. Session 3 involves monitoring the family's progress, discussing any implementation problems, and may also involve the introduction of additional parenting strategies. The aim is to refine the parents' implementation of the routine as required and provide encouragement for their efforts. Session 4 involves a progress review, trouble shooting for any difficulties the parent may be experiencing, positive feedback and encouragement, and termination of contact. If no positive results are achieved after several weeks, the family may be referred to a higher level of intervention.

As with Selective Triple P, this level of intervention is appropriate for the management of discrete child problem behaviors that are not complicated by other major behavior management difficulties or family dysfunction. The key difference is that provision of advice and information alone is supported by active skills training for those parents who require it to implement the recommended parenting strategies. Children would not generally meet full diagnostic criteria for a clinical disorder such as ODD, conduct disorder, or Attention Deficit Hyperactivity Disorder (ADHD), but there may be significant subclinical levels of problem behavior.

A recent study by Sanders, Tully, Turner, and Maher (in press) evaluated the effects of a training program developed specifically for family doctors to provide early detection and brief behaviorally oriented parenting interventions. Thirty-two general medical practitioners (GP's) were assigned to either an experimental group who underwent a brief behaviorally oriented parent consultation skills training program or to a waitlist control group. The parent consultation skills program provided training to participating doctors in the use of the Triple P-Positive Parenting Program. The training consisted of prereading materials, mini lectures, video demonstration and role playing of core consultation skills, competency checks, and clinical problems solving exercises. The results from a practice audit of successive pediatric consultations prior to and following training showed that GPs who had participated in the training showed significant increases in their use of targeted parent consultation skills, and greater satisfaction with the outcomes of their parent consultations. Analysis of simulated parent interviews showed that there were significant overall improvements in interviewing skills during a parent consultation and a high overall satisfaction with the quality of training received.

School as a setting for parenting interventions

The commencement of a child's formal schooling represents another developmental challenge to parents. Children are less likely to develop behavioral problems at school if parents are involved in their child's education and successfully manage difficult behavior at home. At this time enrolling students will consist of children with already established conduct problems, children with subclinical threshold behavior difficulties but who are at risk for the development of disorders and normally developing children. Universal parenting interventions delivered through schools have considerable potential to normalize the parenthood preparation process to help children manage the developmental transition to school. We have recently evaluated a "Transition to School" universal parenting program based on Triple P which targeted all parents of children commencing in grade 1 (McTaggart & Sanders, 2000). The program consists of a universal parenting information campaign through a specially designed school newsletter and group version of Triple P (Turner, Markie-Dadds, & Sanders, 1997). The newsletters consist of 2-weekly one-page newsletters on different positive parenting topics (e.g., promoting children's self esteem, helping children with homework, helping children make friends), which is attached to the regular school newsletter. This newsletter is viewed as an informational "teaser" to encourage parents to enroll in the parenting group. Group Triple P is an eight-session program typically conducted in groups of 10-12 parents. It employs an active skills training process to help parents acquire new knowledge and skills. The program consists of four 2-hour group sessions, which provide opportunities for parents to learn through observation, discussion, practice and feedback. Segments from *Every Parent's Survival Guide* [video] (Sanders, Markie-Dadds, et al., 1996) are used to demonstrate positive parenting skills. These skills are then practiced in small groups. Parents receive constructive feedback about

their use of skills in an emotionally supportive context. Between sessions, parents complete homework tasks to consolidate their learning from the group sessions. Following the group sessions, four 15- to 30-minute follow-up telephone sessions provide additional support to parents as they put into practice what they have learned in the group sessions. Although delivery of the program in a group setting may mean parents receive less individual attention, there are several benefits of group participation for parents. These benefits include support, friendship and constructive feedback from other parents, as well as opportunities for parents to normalize their parenting experience through peer interactions.

McTaggart and Sanders (2000) randomly assigned 25 schools to either the Triple P or usual care control conditions. At the end of grade 1 there were significantly fewer children in Triple P schools who had developed behavior problems (prevention effects) and significantly fewer who continued to show clinically significant levels of disruptive behavior at home. These findings are consistent with other research that shows that the school setting can be a useful social context to support parents of elementary school-age children.

The work site as an intervention context for parenting

An important yet relatively unexplored area is the delivery of parenting interventions as a work site intervention. With the rise in female employment in the paid workforce and the difficulties many parents experience in balancing the dual responsibilities of earning an income and raising a family, increasingly work sites may be viable contexts to provide a range of parenting and family support programs. Work stress can negatively impact on family relationships and conversely, conflict at home can reduce worker productivity, increase occupational burnout, increase industrial accidents and absenteeism. Both men and women can experience difficulties with balancing work and family responsibilities, however there is evidence that this is a particular problem for women (Frankenhaeuser, 1991). The business community has an investment in reducing worker stress arising from family conflict and child management problems. Flexibly delivered work site interventions that provide access to evidence-based parenting programs could be offered as part of an employee assistance program. Internet based delivery of parenting programs is likely to increase significantly in the future and several evaluation trials of this delivery modality are being planned or are underway at present.

The socio-political context

Finally, the broader socio-political system within which funding priorities are determined, needs to be more effectively harnessed. The political system itself is complex and accessing policy makers and key personnel in large bureaucracies can be difficult. Prevention researchers interested in parenting interventions need to be cognizant of the fact that funding support for program innovations occur in a broader sociopolitical context of policy development, political lobbying and advocacy, and public opinion. Political leaders and their policy advisors need to be educated about the prevention agenda. However, family oriented prevention researchers need to become more skilled at this level of advocacy. The political agenda for drug use is complex and often driven by a need to be perceived by voters as being “tough on drugs,” rather than to be tackling the causes of drug use. Hence, prevention scientists need to be more proactive in ensuring informed policy debate and political advocacy, recognizing that the reinforcers for politicians (e.g., electoral appeal, maintenance of power base, avoidance of bad press) may be different from prevention advocates. Clearly diagnosing the reinforcers of key decision makers is an important process.

Conclusions

This paper has argued for the importance of viewing parenting and family interventions as the centerpiece of public health efforts to prevent drug abuse in young people. However, to accomplish this aim parenting needs to be seen as a collective community responsibility, as well as an individual parenting obligation. The approach advocated here has been to target relevant social contexts for parents that potentially provide a nonthreatening, destigmatized access point for high quality, evidence-based parenting information and advice. By using existing social networks, greater community involvement is possible and continuity of care is more easily assured as parents encounter new developmental challenges as their children age.

Prevention researchers need to continue efforts to encourage funding agencies and service providers to use evidence-based parenting and family interventions. The relative lack of uptake of evidence-based interventions is

partly related to lack of knowledge about which are the crucial variables that influence practitioner uptake, implementation, and program integrity under conditions of regular service delivery. Hence, research into the dissemination process itself is greatly needed.

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